



POLICE 110 F Adams

Springfield, IL 62701 FAX: 217-785-0049

Please include all known information and attach copies of all pertinent documentation.

Complaining Party Info	rmation										
Last Name:		First Name:			Middle Initial:		Date of Birth:				
Address:				City:			State:		ZIP Code:		
Driver's License/ID Card Number:			Primary Telephone Number:				Secondary		ne Number:		
Relationship to Subject of Complaint:			Email Address:								
Subject of Complaint											
Last Name:		First Nan	First Name:				Middle Initial:		Date of Birth:		
Address:			City:				State:		ZIP Code:		
Driver's License/ID Card Number:			Primary Telephone				Seco	dary Telephone Number:			
Place of Employment (If Vehicle Dealer, give	e name of Dealership):										
Address:			City:			State:			ZIP Code:		
Dealer Number:		Business Telephone Number:					Sale		Salesperson:		
Vehicle Information (If A	Applicable)	·									
1) Year: Make:				Model:		Color:			r:		
Vehicle Identification Number:			Registration Number:								
2) Year: Make:				Model:		Color:					
Vehicle Identification Number:		Registration Number:				-					
I hereby affirm that the informa my request that the Illinois Secr testify in criminal proceedings a	etary of State Police	e conduc									
Signature of Complainant					Date						
Full Name of	of Complainant (print)			_							
Return To: Illinois Secretary of	State Police,										
(For Office Use Only) Date Rece	eived:	Revie	wed By: _		ID Nur	nber:		[Date:		
Onen Case? Yes No	Case Number					Com	nlaina	nt Notifie	d? Tyes T	1 No	